

IN THE UNITED STATES PATENT AND TRADEMARK OFFICE  
APPLICATION FOR U.S. LETTERS PATENT

Title:

INSERT MOLDED PUSH-IN SUTURE ANCHOR

Inventors:

William C. Benavitz  
R. Donald Grafton  
Reinhold Schmieding

Peter F. McGee  
DICKSTEIN SHAPIRO MORIN &  
OSHINSKY LLP  
2101 L Street NW  
Washington, DC 20037-1526

## INSERT MOLDED PUSH-IN SUTURE ANCHOR

[0001] This application is a continuation-in-part of U.S. Application Ser. No. 09/495,816, filed February 2, 2000 and claims the benefit of U.S. Provisional Application Serial No. 60/118,228, filed February 2, 1999 and U.S. Provisional Application Serial No. 60/125,781, filed March 23, 1999, the disclosures of which are incorporated herein by reference. This application also claims the benefit of U.S. Provisional Application Serial No. 60/271,414, filed February 27, 2001.

### BACKGROUND OF THE INVENTION

#### 1. Field of the Invention:

[0002] The present invention relates to an apparatus and method for anchoring surgical suture to bone. More specifically, the present invention relates to arthroscopic apparatus and methods for anchoring suture to bone using a push-in suture anchor having suture molded directly into the body of the suture anchor.

#### 2. Description of the Related Art:

[0003] When soft tissue tears away from bone, reattachment becomes necessary. Various fixation devices, including sutures, screws, staples, wedges, and plugs have been used in the past to secure soft tissue to bone. More recently, various types of threaded suture anchors have been developed.

[0004] Suture anchors and implants generally include a structure for attaching or securing the suture to the anchor. U.S. Patent No. 4,632,100, for example, discloses and

claims a threaded suture anchor with a complex press-fitted disc and knot structure which secures the suture to the anchor. In other suture anchors, such as those disclosed in U.S. Patent No. 5,370,662, the suture is attached to the anchor by passing the suture through an eyelet at the back end of the anchor. Problems can arise if the structure for attaching the suture fails, allowing the suture to become detached from the anchor. Also, in some of the known devices, the suture is exposed to abrasion or cutting by sharp or rough areas along the walls of the bone canal into which the anchor is inserted.

[0005] In addition, the eyelet or, in the case of U.S. Patent No. 4,632,100, the axial opening for receiving the disc to which the suture is knotted, is formed as part of the drive head of the known suture anchors, which weakens the drive head. Various other modifications in the drive head are often employed in connection with suture attachment. For example, recessed grooves may be formed on opposite sides of the drive head to receive and protect the suture from the abrasive areas of the suture anchor tunnel. In such cases, the drive head often is made of a larger diameter to recover the mechanical strength lost from the removal of material relating to the suture-attachment or suture-protection modification.

[0006] Accordingly, a need exists for a suture anchor or implant to which suture is secured effectively so as to prevent detachment of the suture. A need also exists for a soft tissue fixation device having a low profile configuration particularly suited for reattachment of tissue to the glenoid rim, for example.

## SUMMARY OF THE INVENTION

[0007] The suture anchor of the present invention overcomes disadvantages of the prior art, such as those noted above, and achieves the foregoing objectives by providing a push in suture anchor having suture insert-molded into the suture anchor during the manufacturing process.

[0008] At least one length of the insert-molded suture extends from the proximal end of the suture anchor body. Both the suture anchor and suture preferably are made with biodegradable materials. According to one embodiment, irregularities are formed along the surface of the suture, especially where it is molded inside the suture body, to increase pullout strength of the suture from the anchor body. The surface irregularities can be formed by various methods including incorporating a thick fiber into the weave of the suture or by tying knots in the suture.

[0009] The push-in suture anchor of the present invention has a central body, a distal end, and a proximal end. The body preferably has tapered ribs formed along the distal portion, terminating in a blunt or rounded proximal end. The proximal end of the suture anchor body preferably has a round, tapered drive head which is received in a recess of a hand driver.

[0010] The insert-molded suture preferably extends through the entire length of the anchor and exits at the proximal end of the anchor. In a preferred embodiment of the invention, the suture forms a loop outside the proximal end of the anchor. Advantageously,

the suture exits the suture anchor along the central axis of the anchor, which prevents suture abrasion by the wall of the bone tunnel into which the anchor is inserted.

[0011] Other features and advantages of the present invention will become apparent from the following description of the invention, which refers to the accompanying drawings.

#### BRIEF DESCRIPTION OF THE DRAWINGS

[0012] Fig. 1 is a plan view of the push-in suture anchor of the present invention.

[0013] Fig. 2 is a sectional elevation of the suture anchor of Fig. 1.

[0014] Fig. 3 is a proximal end view of the suture anchor of Fig. 1.

[0015] Fig. 4 is a plan view of a hand driver for inserting the push-in suture anchor of the present invention.

[0016] Fig. 5 is an elevation view of the hand driver of Fig. 4.

[0017] Fig. 6 is a sectional view of the hand driver of Fig. 4.

[0018] Fig. 7 is a detail view of the drive end of the hand driver of Fig. 4.

[0019] Fig. 8 is a plan view of an alternative hand driver for a method of capsular plication using the push-in suture anchor according to the present invention.

[0020] Fig. 9 is an elevational view of the hand driver of Fig. 8.

[0021] Fig. 10 is a sectional elevation of the hand driver of Fig. 8.

[0022] Fig. 11 is a detail view of the drive end of the hand driver of Fig. 4.

#### DETAILED DESCRIPTION OF THE PREFERRED EMBODIMENTS

[0023] Referring to Figs. 1-3, the present invention is shown as a push-in suture anchor 2 having suture 4 that is insert-molded directly into the suture anchor body 6 during the manufacturing process.

[0024] The suture anchor body 6 preferably is formed of a bioabsorbable material, poly(l-lactide-co-d,l-lactide) 70:30 (PLDLA) being most preferred. Suture 4 can be any known type of suture selected according to the size of the anchor and the anticipated application. The suture 4 preferably is No. 2 polyester braided suture.

[0025] At least one length of the insert-molded suture 4 extends from the proximal end of the suture anchor body. Preferably, the suture extends from the suture anchor body in the form of a loop. Various methods of increasing the pull out strength of the suture from the anchor body are disclosed in U.S. Pat. No. 5,964,783 to Grafton et al. which issued on October 12, 1999 and is assigned to the present applicant, the entire disclosure of which are incorporated herein by reference.

[0026] The proximal end 8 of the suture anchor body preferably is tapered for a snug fit into a hand driver described below, for example, with reference to Figs. 4-7. The distal

end **10** of the suture anchor tapers to a blunt tip. Suture anchor **2** is provided with slotted ribs **12** formed circumferentially at least partially around and partially along the length of body **6**. Ribs **12** have a truncated, conical shape, each rib increasing in diameter toward the head of the anchor at an angle of preferably 15° with respect to the longitudinal axis of anchor **2**, and reaching a major diameter of 3.0 mm. Slots **14** are formed in ribs **12** on alternating sides of body **4**.

[0027] Referring to Figs. 4-7, a hand driver **20** according to the present invention is shown. Hand driver **20** includes a cannulated shaft **22** with a cannulated handle **24**. A cleat **26** is provided on the handle for securing suture attached to the suture loop on the suture anchor and passed through the cannulated shaft and handle. The distal tip **28** of cannulated shaft **22** provides a recess **30** which receives the proximal end of suture anchor **2**. The outer diameter of the distal end of the driver preferably is less than or equal to the maximum outer diameter of the suture anchor.

[0028] The suture anchor is pushed into a hole formed in bone. The hole can be formed by punching or boring, for example. The ribs secure the anchor in the bone. The slots enhance attachment in the bone and support bony in-growth for increased pull out strength.

[0029] Advantageously, the hole formed in bone is made deep enough, and the suture anchor is advanced into the hole sufficiently, so that the proximal end of the anchor sits flush with or below the bone surface. Accordingly, the repair leaves a smooth bone surface, minimizing or eliminating abrasion or other damage to surrounding soft tissue. The

anchor generally becomes encapsulated by fibrous tissue within six weeks after implantation.

[0030] Although PLDLA is the most preferred material for the suture anchor of the present invention, other bioabsorbable materials known in the art can be utilized. As used herein, bioabsorbable is considered to be interchangeable with biodegradable, resorbable and absorbable to mean that the device can be at least partially absorbed by the body over time. Preferably, the anchor material is selected so as to absorb or degrade substantially completely within 12-16 months of implantation.

[0031] The push-in suture anchor of the present invention is particularly well suited for reattachment of the glenoid labrum or inferior glenohumeral ligament in patients with primary or recurrent anterior dislocation or subluxation of the shoulder in association with adequate post-operative immobilization. More specifically, the anchor also can be used for repair procedures such as capsulabral plication, as described below.

[0032] Referring to Figs. 8-11, a driver **40** for capsule plication using the anchor according to the present invention is shown. Capsulolabral plication is indicated for repair of certain types of shoulder laxity. When pathologically increased anterior laxity is combined with a Bankart lesion, for example, the addition of a capsular plication to the reattachment of the capsulolabral avulsion has been recommended.

[0033] Driver **40** includes a cannulated shaft **42** with a cannulated handle **44**. A cleat **46** is provided on the handle for securing suture attached to the suture loop on the suture anchor and passed through the cannulated shaft and handle. The distal tip **48** of

cannulated shaft **42** provides a recess **50** which receives the proximal end of suture anchor

2. The outer diameter of the distal end of the driver preferably is less than or equal to the maximum outer diameter of the suture anchor. Driver **40** also features a slot **42** which is continuous with recess **50**.

[0034] The method of capsular plication proceeds using a 36-inch (91.4 cm) long #2 suture to plicate the capsulolabral complex. Both free ends of the suture are brought out an operative cannula. A spear with an included obturator is introduced through a skin incision or a clear cannula. The tip of the spear is positioned on bone and the obturator is removed.

[0035] A pilot hole is prepared in bone using either a punch or a drill depending on surgeon preference. With the manual punch, a mallet is used to advance the punch into bone until the punch handle meets the back of the spear and/or the shoulder on the distal part of the punch meets the bone surface. Alternatively, the drill can be attached with a Jacob chuck to a motorized drill and advanced until the stop on the drill bit meets the back of the spear.

[0036] After the pilot hole is created and the punch or drill is removed, the sterile-packaged implant **2** is opened to the sterile field using appropriate sterile technique. The implant is removed from the standard hand driver **20** and the suture is unloaded from the implant. A separate sterile packaged plication driver **40** is opened to the sterile field. One of the two legs of the plication suture is selected. This suture leg is the one on the medial side, or the one that passes under the tissue.

[0037] The selected suture leg is loaded through the implant eyelet. The implant 2 is positioned on plication driver 40 so that the open side of the eyelet 4 faces the open slot 52 on the driver. The suture leg will exit the slot 52 on the driver 40. The implant with driver is pushed into the prepared pilot hole by hand. A mallet then is used to advance the implant into the hole. The implant is advanced until a second laser line 54 on the distal tip of the driver is flush with the bone surface and a laser line 56 on the proximal part of the implant driver shaft is flush with the back of the spear handle.

[0038] The implant driver handle is pulled straight off the implant and the spear is removed. Additional implants are inserted dependent upon the size of the soft tissue defect. Suture passing and knot tying are carried out in the preferred fashion.

[0039] Although the present invention has been described in relation to particular embodiments thereof, many other variations and modifications and other uses will become apparent to those skilled in the art.